PRINTED: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION  IILDING			(X3) DATE SURVEY COMPLETED	
		17E294	B. WING _			06/	03/2014	
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOSP	ITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP COL 408 DELAWARE ST WINCHESTER, KS 66097	DE .			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F 0	00				
F 157 SS=D	complaint investigation 483.10(b)(11) NOTIF (INJURY/DECLINE/R)  A facility must immediate consult with the resident known, notify the resion or an interested familial accident involving the injury and has the position intervention; a significal physical, mental, or produced the deterioration in health status in either life the clinical complications significantly (i.e., a nexisting form of treatment); or a decist the resident from the §483.12(a).  The facility must also and, if known, the resor interested family mechange in room or roospecified in §483.15(resident rights under regulations as specifithis section.  The facility must record the address and phoresident rights under regulations and phoresident rights and phoreside	iately inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a an mental, or psychosocial reatening conditions or an ened to alter treatment the doubt of the	F 1	57				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		17E294	B. WING _			C 06/03/2014		
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOS	PITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097				
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F 157	by: The facility reported The sample was 3 r observation, intervie facility failed to notif 1 (#2) resident that r medication used to d Findings included:  - Review of the Adm (MDS) for resident # Brief Interview for M 5 which indicated se Review of the cogni Assessment (CAA) resident had periods Review of the behave revealed the resider persistent belief or p although evidence se hallucinations (seens appear to be real, be suspicion and parar believed to be heave fear to the point of in Review of the fall Corresident liked his/he call for help, occasion bed or wheelchair to respond well to rem help. Review of the quarte revealed a BIMS so severe cognitive imp usually understood, delusions. The residence	IT is not met as evidenced If a census of 31 residents, esidents. Based on ew and record review the year the physician of bruising for received Coumadin (a decrease blood clotting).  Inission Minimum Data Set to decrease blood clotting).	F 1	57				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION (IDENTIFICATION NUMBER			I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING		C 06/03/20 <sup>2</sup>	14
NAME OF PROVIDER OR SUPPL	IER			STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097	1 00/03/20	14
PREFIX (EACH DE	IARY STATEMENT OF DEFI FICIENCY MUST BE PRECE DRY OR LSC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMP	X5) PLETION ATE
anticoagulation blood clotting) physician for so bleeding or bru Review of the revealed the responsibility (anticoagulant) Review of the P.M. the staff of the closet in Review of the A.M. revealed x 4 cm raised by forehead area, motion (ROM) were within no remember hitti. Observation on the resident saroom; the resident saroom; the resident saroom; the right forehead in diameter, roothe right forehead in the resident staff notified the resident's forely staff C stated by staff notified the resident's forely that received of 483.20(d), 483 COMPREHEN. A facility must	oileting. revised care plan date in (a medication used in revealed staff were to gns and symptoms of ising. Ohysician's order date isident was to receive in 7 milligrams daily. Inurses' note dated 5/3 ound the resident on the sitting position. Inurses' note dated 5/3 the resident had 5 ce orownish/yellow bruise The resident denied was within normal limiter and limits, and the reing his/her head. In 5/28/14 at 12:10 P.M. It in the wheelchair in lent had bruising from loss the right eye and I bump approximately se 3/4 inches and was lead. 29/14 at 12:25 P.M. at lee/she was unable to lee doctor of the bruisin lend to notify the physic lend to notify the physic lend to notify the physic lend to the face for the	to decrease on notify the funusual ed 5/15/14 e Coumadin 3/14 at 11:00 floor in front 5/14 at 8:10 ntimeter (cm) e to the right pain, range of hits, vital signs esident did not sesident did not w. revealed the dining in the right right cheek. If you arter size located on administrative determine if high to the cian in a timely is resident.	F 15			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING		C 06/03/2014
	ROVIDER OR SUPPLIER  DN COUNTY MEM HOS	PITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097	1 33.33.2311
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 279	plan for each reside objectives and timet medical, nursing, ar needs that are ident assessment.  The care plan must to be furnished to at highest practicable psychosocial well-be §483.25; and any se be required under § due to the resident's	velop a comprehensive care nt that includes measurable ables to meet a resident's d mental and psychosocial ified in the comprehensive describe the services that are tain or maintain the resident's ohysical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under ne right to refuse treatment	F 2'	79	
	by: The facility reported The sample included observation, intervie facility failed to upda plans for falls for 2 ( reviewed for falls.  Findings included:  Review of the Adr (MDS) dated 7/10/1 Brief Interview for M 5, which indicated s  Review of the Quart revealed a BIMS so	T is not met as evidenced If a census of 31 residents. If a sesidents are and a record review the set and individualize care #2, #3) of 3 residents In the series of the series are are and individualize care #2, #3) of 3 residents In the series of the ser			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 279	had delusions (untruperception held by a shows it was untrue) independent for mobresident's room, dresident's room, dresident's room, dresident had periods.  Review of the cognit Assessment (CAA) oresident had periods.  Review of the behave revealed the resident hallucinations (sensiappear real, but the paranoia (a thought heavily influenced by of irrational thinking).  Review of the fall CA resident liked his/her call for help, occasion bed or wheelchair to respond well to remithelp.  Review of the Care If the record lacked do 5/3/14 and no intervent additional falls.  Interview on 5/29/14 licensed staff C state on the care plan upon Review of the nurse.	and understood others, and be persistent belief or person although evidence by The resident was polity, transfers, walking in the essing, and toileting.  In the loss Care Area dated 7/10/13 revealed the evolution of confusion.  It had delusions, and the subject of the point of	F 2	79				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
F 279	the resident sat in the bruise noted to the Observation on 5/2 sat in the doorway area noted to the frinch in elevation, we resident's scalp whithe resident's eye araised area noted to the resident's eye araised area noted to the ankled On 5/29/14 at 8:15 bed with the door to the light of the state of t	8/14 at 12:10 P.M. revealed he wheelchair with a large right side of the face. 8/14 at 3:00 P.M. the resident of his/her room. A large raised prehead, approximately one ith discoloration of the ich included the area around area and cheek, and a large of the right upper shin on the earea.  A.M. the resident rested in the room nearly closed.  4 at 3:00 P.M. the resident when he/she got the ladder out get something out of his/her bout 2 weeks ago. The ladder not in a different room.  3 A.M. licensed staff E stated the care plan update for falls alls with a new intervention.  4 at 11:38 AM administrative ted comprehensive care plans the MDS coordinator and care d by the nursing staff.  prehensive Care Plan policy ility revised 10/10 revealed the sessments of the resident and vised as the resident's	F2	279			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		IPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING _				C <b>03/2014</b>
	ROVIDER OR SUPPLIER  DN COUNTY MEM HOSI	PITAL LTCU		408 DELAWA	RESS, CITY, STATE, ZIP CODE RE ST ER, KS 66097	, 33.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E OSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE	
F 279	Continued From pag	e 6	F 2	79			
	Minimum Data Set (M						
	revealed a BIMS sco severe cognitive imp unclear speech, usua sometimes could be resident required ext bed mobility, transfer personal hygiene. To and able to stabilize seated to standing, we toilet, and surface to resident had impairm	rly MDS 3.0 dated 4/16/14 re of 3 which indicated airment. The resident had ally understood, and understood by others, The ensive assist of one staff for rs, dressing, toileting, and he resident was not steady with staff for moving from valking, moving off and on surface transfer. The tent on one side of his/her valker and wheelchair for					
	dated 7/23/13 for cog resident had aphasia	Area Assessment (CAA) gnitive loss revealed the (condition with disordered unction and responded with					
	to partial foot amputa of depression, and a foot. The resident us chair cushion with a thighs) in the chair to assistance, a floor m quarter side rail to as	ated 7/23/13 for falls t was a high risk for falls due ation in the 1960's, a history n orthotic shoe for the right sed a pummel cushion (a raised area between the discourage standing without at next to the bed, and sist with repositioning.					

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F 279	spend time by the fir between meals for ir prevent falls, staff wand offer toileting ev footwear when up ar controls were moved bed, staff were to chand fall mats in front Review of the care p 5/10/14 revealed state alarm so the resident, accompany the rethe time the resident encourage this (coguse the call light, we times, and to toilet the Review of the revise care plan update for checking the placemalarm.	resident was encouraged to replace in the recliner encreased monitoring to ere to continue to reposition ery 2 hours, appropriate and with ambulation, bed at to the bottom outside of the eck the position of the bed,	F 2	<u> </u>			
	prevention of falls.  Observation on 5/28 the resident was in the position, a fall mat we personal alarm was  Observation on 5/28 the resident sat in the	new interventions for the //14 at 11:05 A.M. revealed bed, the bed was in the low ras next to the bed, and a at the head of the bed. //14 at 11:39 A.M. revealed e wheelchair in the dining I alarm was attached to the he wheelchair.					

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F 280 SS=D	resident sat in the wh A personal alarm was shirt on the right should be resident was in be located above the pill. Interview on 5/29/14 at licensed staff C stated on the care plan updated on the care plan updated by the Compressive of the C	14 at 7:30 A.M. revealed the eelchair in the dining room. It is attached to the resident's alder and the wheelchair.  14 at 11:09 A.M. revealed ed and a personal alarm was low at the head of the bed.  15 at 12:25 P.M. administrative ed there should be an entry late of falls for each fall.  16 AM administrative licensed thensive care plans were entry late of the nursing staff.  17 School of the resident and led as the resident's entry late of the personal led and measurable entry late of the prevention of la		280			
		g care and treatment or					

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F 280	within 7 days after to comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deternand, to the extent p the resident, the resident interesident in the resident in	ge 9  are plan must be developed he completion of the essment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's r; and periodically reviewed am of qualified persons after	F 28	30			
	by: The facility reporter The sample include observation, record facility failed to revie for 1 (#1) resident of  Findings included:  - The significant ch Set dated 3/25/14 fr Interview for Mental impaired cognition). extensive assistance with bed mobility, tr room, and toilet use extensive assistance locomotion on the u hygiene and total de physical assist with	ange in status Minimum Data or resident #1 revealed a Brief Status score of 0 (severe The resident required e of two plus (2+) persons ansfers, walking in her/his the resident also required					

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE COMPLETION
F 280	standing position, was facing the opposite of moving on and off the surface transfer. The limitations in her/his walker and wheelchast resident had two or readmission/entry consistently note resident where oppositely of the fact that the seat of the seat of the wind in the pedside.  The revised care plassion of the resident's eye glassion of the eye glassion of the resident's eye glassion of the resident's alarming staff worther resident's alarming on sistently note resident's of the resident's alarming on sistently note resident's alarming on sistently note resident's alarming on sistently note resident's resident's alarming on sistently note resident's resident's resident's resident's alarming on sistently note resident's res	n moving from seated to alking, turning around and irection while walking, e toilet, and surface to resident had no functional range of motion and used a air (w/c) for mobility. The more non-injury falls since e-entry or prior assessment.  Sesessment dated 3/25/14 to required nursing staff of the resident was at risk for states. The resident had difficulty would bend forward at the lish happened when she/he are self, or to walk alone. The neel cushion (a cushion with a protuberance at the front dent from slipping down on which kept her/him from ard but became strong the protuberance at the front dent from slipping down on which kept her/him from ard but became strong the protuberance at the front dent from slipping down on which kept her/him from ard but became strong the protuberance at the front dent from slipping down on which kept her/him from ard but became strong the protuberance at the front dent from slipping down on which kept her/him from ard but became strong the provided throughout the day. The suse her/his walker, and ding pad, for falls from or by the dated 4/10/14 listed the graff would maintain the test in clean working order and the ses to her/him daily during provided a bed/chair alarm ald respond immediately to when sounded, would ident's whereabouts for the resident outside when	F 28		

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F 280	or grippers socks.  The revised care plat documentation the relow position, border were placed on both and the chair/bed also function on every sharment Administration on every sharment Administration on 5/28 resident laid in the bostion, a border aid the call light was with pulled the bedding at a white plastic alarm.  Observation on 5/29 resident laid in a low air mattress, call light landing mat placed at resident's bed.  Interview on 5/28/14 staff G stated the reconsisted of bed/chafall mats, frequent vitwo hours, a gait bel within reach when in staff G stated she/he had a high/low bed.  Interview on 5/29/14 nursing staff E state intervention consisted a border mattress, a sock/shoes, and a g	and provided non-slip shoes an dated 4/10/14 lacked esident's bed was placed in a air mattress, landing mats isides of the resident's bed, arms were checked for ift and documented on the rative Record (TAR).  1/14 at 1:05 P.M. revealed the ed with the bed in low r mattress was in place, and hin reach. Direct care staff G iside and the resident laid on in pad.  1/14 at 7:15 A.M. revealed the repositioned bed with a border at within reach, a foam along both sides of the  1/156 P.M. with direct care esident's fall interventions air alarm, a border mattress, sual checks of at least every t with transfers, and call light in her/his room. Direct care e was not sure if the resident  1/12 A.M. with licensed	F 28	30			

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F 280	Continued From page		F 28	80		
F 309 SS=D	plan and updated by Interview on 5/29/14 administrative nursing completed the compr quarterly and nursing The revised policy an 2010 titled Senior Liv Comprehensive reve- care plan was based which included, but w The facility failed to re prevention of falls for resident with a histor 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must re provide the necessar or maintain the highe mental, and psychose accordance with the ca and plan of care.  This REQUIREMENT by: The facility reported The sample included observation, record re facility failed to monit	at 11:38 A.M. with g staff B stated she/he ehensive nursing care plan staff revised the care plan.  d procedure dated Octobering Center Care Plans - aled the comprehensive on a thorough assessment ras not limited to, the MDS.  evise the care plan for the this cognitively impaired of a fall with fracture.  IRE/SERVICES FOR NG  ecceive and the facility must y care and services to attain st practicable physical,	F 30	9		
	i indingo indiducu.					

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F 309	Continued From pag	e 13	F 30	9		
	Data Set dated 3/25/Brief Interview for Me (severe impaired cogrequired extensive a persons with bed mother/his room, and toi required extensive a locomotion on the urnygiene and total de physical assist with besteady and was only staff assistance with standing position, was facing the opposite of moving on and off the surface transfer. The limitations in her/his walker and wheelcharesident had two or radmission/entry or resident had two or radmission/entry or resident processes. The fall Care Area A revealed the resident assistance with transwas not safety consorthought processes. Talls and had two fall with sitting balance waist. Most of the fa attempted to transfer resident had a pomman upward-projecting part to prevent a resident had a pomman upward-projec	ange in Status Minimum  14 for resident #1 revealed a ental Status score of 0 gnition). The resident ssistance of two plus (2+) sbility, transfers, walking in let use. The resident also ssistance of one person for nit, dressing, personal pendence of one person bathing. The resident was not able to stabilize with nursing moving from seated to alking, turning around and lirection while walking, the toilet, and surface to the resident had no functional trange of motion and used a sir (w/c) for mobility. The more non-injury falls since the-entry or prior assessment.  Ssessment dated 3/25/14 the required nursing staff the resident was at risk for states. The resident had difficulty would bend forward at the alls happened when she/he the self, or to walk alone. The mel cushion (a cushion with the protuberance at the front dent from slipping down on which kept her/him from and but became strong the protuber of the resident had difficulty would became strong the protuberance at the front dent from slipping down on which kept her/him from and but became strong the protuber of the resident had difficulty the protuber of the resident had dent from slipping down on which kept her/him from and but became strong the protuber of the resident had dent the resident had dent the resident had dent the resident had difficulty the protuber of the resident had the protuber of the resident had the protuber of the resident had the				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
F 309	had a cushioned land the bedside.  The revised care plar interventions nursing resident's eye glasse provide the eye glasse waking hours, family and nursing staff wou the resident's alarm v consistently note resi	s use her/his walker, and ing pad, for falls from or by a dated 4/10/14 listed the staff would maintain the s in clean working order and es to her/him daily during provided a bed/chair alarm ld respond immediately to when sounded, would dent's whereabouts for	F3	509			
	weather permitted, ar or grippers socks.  The nursing notes (N A.M. revealed the nursitting on the floor in buttock covered in unwet with urine. The re (ROM) was normal. N noted. The bed alarm personal body alarm refused to allow nursivital signs and she/her Record review on 5/2 documentation neuro.  The NN dated 3/12/14 director informed nursithe floor between a reresident had good RO all extremities without Record review on 5/2.	was obtained. The resident ng staff to obtain her/his e denied pain or discomfort.  9/14 at 9:29 A.M. lacked checks were initiated.  4 at 11:15 A.M. the activity sing staff the resident sat on ecliner and the wall. The DM, and was able to move					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		17E294	B. WING _			C 06/03/2014		
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOS	SPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097		, 55555		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 309	nursing staff found her/his buttocks. The from a recliner chain and did not grimace her/his extremities, was noted.  Record review on 5 documentation neuron the nursing notes a 5/2/14 at 8:20 A.M. resident on the flood between a w/c and complained of right 10 (being the worst notified and an order Record review on 5 documentation neuron the call light was wirevealed the reside pad.  Observation on 5/2 resident laid in bed position, a border at the call light was wirevealed the reside pad.  Observation on 5/2 direct care staff F afrom her/his bed to gait belt.  Interview on 5/29/14 nursing staff E state checks with a fall if resident hitting their resident hitting their resident hitting their staff the state of the call in the staff of t	ge 15 /14 at 5:00 P.M. revealed the resident on the floor on the resident tried to ambulate or to her/his w/c, denied pain or guard with ROM of all and no redness or bruising //29/14 at 9:29 A.M. lacked or checks were initiated.  and care plan revealed on nursing staff found the or laying on her/his right side or recliner. The resident arm/shoulder pain scoring a pain). The physician was or for an x-ray was obtained. //29/14 at 9:29 A.M. lacked or checks were initiated. //29/14 at 9:29 A.M. lacked or checks were initiated. //29/14 at 1:05 P.M. revealed the with the bed in the low ir mattress was in place, and thin reach. Direct care staff G ont laid on a white plastic alarm ///20/14 at 7:45 A.M. revealed ond H transferred the resident wheelchair with the use of a ///4 at 10:12 A.M. with licensed ded nursing staff initiated neuro there were suspicions of the r head, if the resident was or hit their head, and if a	F3	09				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		17E294	B. WING		06/03/2014		
	ROVIDER OR SUPPLIER ON COUNTY MEM HOS	SPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097	1 00/03/2014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE COMPLETION		
F 309	initiated neuro chec unwitnessed, when state if they hit their witnessed a resider should have initiated May 2, 2014.  The revised policy a 2010 titled Senior L Investigation, and P event the resident had or the resident was did not hit her/his had initiated and perform	thit their head  4 at 11:38 A.M. with ng staff B stated nursing staff ks with falls that were the resident was unable to head, and if nursing staff at hit their head. Nursing staff d neuro checks with the fall on  and procedure dated October iving Center Falls, Reporting, revention revealed in the ait her/his head during the fall unable to confirm that she/he ead, neuro checks would be ned by the charge nurse.  initiate neuro checks after ir this cognitively impaired	F 309				
	(MDS) for resident a Brief Interview for M 5 which indicated so Review of the cogni Assessment (CAA) resident had period: Review of the behave revealed the resider persistent belief or p	dated 7/10/13 revealed the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		17E294	B. WING _			C <b>06/03/2014</b>	
	ROVIDER OR SUPPLIER  ON COUNTY MEM HO	OSPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP 408 DELAWARE ST WINCHESTER, KS 66097	•	33.33.23.1	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	appear to be real, suspicion and parabelieved to be hear fear to the point of Review of the fall of resident liked his/hocall for help, occasibed or wheelchair respond well to renhelp.  Review of the Quarevealed a BIMS is severe cognitive in usually understood had delusions (untiperception held by shows it was untruindependent for more sident's room, drawing the staff found front of the closet in Review of the nurse A.M. revealed the x 4 cm raised browforehead area.  Review of the Carestaff failed to do not unwitnessed fall of resident.  Observation on 5/2	using things while awake that but the mind created), anoia (a thought process vily influenced by anxiety or	F3	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		17E294	B. WING _			C 06/03/2014	
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOS	PITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODI 408 DELAWARE ST WINCHESTER, KS 66097	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	sat in the doorway of area noted to the for inch in elevation, with resident's scalp which the resident's eye arraised area noted to leg and to the ankle.  On 5/29/14 at 8:15 A bed with the door to linterview on 5/29/14 E stated neurological resident was unable was questionable with was unable to state in neurological checks.  Review of the fall porevised 10/10 reveal neurological checks resident hit their hear the facility failed to it on this cognitively in unwitnessed fall.  - Review of the sign Set (MDS) 3.0 for rerevealed a Brief Interior in the scale of the sign set (MDS) 3.0 for rerevealed a Brief Interior in the scale of the sign set (MDS) 3.0 for rerevealed a Brief Interior in the scale of the sign set (MDS) 3.0 for rerevealed a Brief Interior in the scale of the sign set (MDS) 3.0 for rerevealed a Brief Interior in the scale of the sign set (MDS) 3.0 for rerevealed a Brief Interior in the scale of the scale of the sign set (MDS) and for rerevealed a Brief Interior in the scale of the scale of the sign set (MDS) and for rerevealed a Brief Interior in the scale of the scal	ight side of the face.  /14 at 3:00 P.M. the resident f his/her room. A large raised ehead, approximately one h discoloration of the ch included the area around ea and cheek, and a large the right upper shin on the area.  A.M. the resident rested in the room nearly closed.  at 10:12 A.M. licensed staff all checks were initiated if a to say they hit their head, if it the fall and the resident injury to head then should be completed.  licy provided by the facility ed the staff were to do if unable to determine if the d.  initiate neurological checks apaired resident after an  ificant change Minimum Data sident #3 dated 7/23/13 rview for Mental Status nich indicated severe	F3	309			
		Area Assessment (CAA) gnitive loss revealed the					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING _				03/2014
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOSE	PITAL LTCU		408	REET ADDRESS, CITY, STATE, ZIP CODE  DELAWARE ST  NCHESTER, KS 66097	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	or absent language for few words).  Review of the common revealed the resident (progressive mental of failing memory, confuterm memory deficits  Review of the quarter revealed a BIMS score severe cognitive imparts and the president required extends bed mobility, transfer personal hygiene. The and able to stabilize to seated to standing, with the toilet, surface to so on one side, and use for mobility.  Review of the revised for mobility.  Review of the revised for mobility.  Review of the revised for meals for increased restaff were to continue toileting every 2 hour when up and with amonths.	(condition with disordered unction and responded with unication CAA dated 7/23/13 had aphasia, dementia disorder characterized by usion with short and long ).  Ty MDS 3.0 dated 4/16/14 re of 3 which indicated airment. The resident had	F	309			
	toilet.  Review of the care pl 5/10/14 revealed staf alarm so the resident	bed, and fall mats in front of an update of falls dated f were to attach the personal could not reach and remove sident for toileting, decrease					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER'SUPPLIER'CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		17E294	B. WING		06/03/2014		
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOS	SPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097	1 00/03/2014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 309	encourage this (cog use the call light, we times, and to toilet to Review of the nurse A.M. revealed staff in the bathroom sitti wall.  Review of the nurse 10:55 A.M. revealed on his/her left side wand knees bent.  Review of the nurse P.M. revealed staff left side.  Review of the nurse P.M. revealed staff the floor in the bathroom.  Review of the nurse A.M. revealed staff of his/her room.  Review of the nurse 11:45 A.M. revealed the floor in the door Review of the nurse P.M. revealed staff of his/her room.	It stayed in bed, a bed alarm, initively impaired) resident to ear non-skid socks at all he resident more often.  It's note dated 3/24/14 at 1050 found the resident on the flooring upright with back against.  It's note dated 3/29/14 at distaff found the resident lying with back towards bathroom.  It's note dated 4/1/14 at 4:25 found the resident on his/her.  It's note dated 4/24/14 at 5:25 found the resident sitting on room doorway of his/her.  It's note dated 4/28/14 at 8:30 found the resident on the floor.  It's note dated 5/10/14 at distaff found the resident on way of his/her bathroom.  It's note dated 5/13/14 at 5:45 found the resident on the et and his/her head by the or frame.	F 30				
		lacked evidence neurological d for these unwitnessed falls					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E294	B. WING _			l	03/2014
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOSP	ITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP C 408 DELAWARE ST WINCHESTER, KS 66097	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 323 SS=G	the resident was in be position, a fall mat wa personal alarm was a Observation on 5/29/2 the resident was in be located above the pill. Interview on 5/29/14 a E stated neurological resident was unable t if it was questionable state injury to head the should be completed. Review of the fall poli revised 10/10 revealed neurological checks if injury to head.  The facility failed to inform this cognitively impunitinessed fall.  483.25(h) FREE OF A HAZARDS/SUPERVITHE facility must ensure environment remains as is possible; and each and the position of the facility must ensure environment remains as is possible; and each and the position of the position of the facility must ensure environment remains as is possible; and each alarm was an each al	red, aphasic resident.  14 at 11:05 A.M. revealed ed, the bed was in the low is next to the bed, and a it the head of the bed.  14 at 11:09 A.M. revealed ed and a personal alarm was low at the head of the bed.  15 at 10:12 A.M. licensed staff checks were initiated if a low say if they hit their head, with the fall and unable to en neurological checks.  16 cy provided by the facility of the staff were to do inable to determine now it is to determine a control of the c	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	COMI	(X3) DATE SURVEY COMPLETED		
		17E294	B. WING _		l	C / <b>03/2014</b>	
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOSE	PITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	by: The facility reported The sample included observation, record r facility failed to provid for 2 (#1 and #3) resiresident sustained a Findings included:  - The Significant Character of the Significant Character of Me (severe impaired cogrequired extensive as persons with bed mon her/his room, and to required extensive as locomotion on the unhygiene and total dephysical assist with besteady and was only staff assistance with standing position, was facing the opposite demoving on and off the surface transfer. The limitations in her/his walker and wheelcharesident had two or nadmission/entry or resident transfer. The surface transfer or admission/entry or resident had two or nadmission/entry or resident transfer. The surface transfer or admission/entry or resident had two or nadmission/entry or	a census of 31 residents. 3 residents. Based on eview, and interview, the de interventions as planned dents who fell and one fracture.  ange in Status Minimum 14 for resident #1 revealed a ental Status score of 0	F3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		17E294	B. WING		06/03/2014	
	ROVIDER OR SUPPLIER  ON COUNTY MEM HOS	PITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE  408 DELAWARE ST  WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 323	the waist. Most of t she/he attempted to alone. The resident cushion with a upwa the front part to previous on the seat) in from sliding or falling enough to stand up ambulatory abilities. She/he did not alwa had a cushioned lar the bedside.  The revised care plast for social isolation, a cognition and commit degeneration (progretina) and difficulty activities listed the inwould maintain the clean working order to her/him daily durity provided a bed/chainwould respond immit alarm when sounded resident's whereabouthe resident outsided provided non-slip should be the floor of buttock covered in the two with urine. The (ROM) was normal. The intervention was	and would bend forward at the falls happened when transfer self, or to walk had a pommel cushion (a ard-projecting protuberance at went a resident from slipping the w/c which kept her/him g forward but became strong beyond the cushion. Her/his varied throughout the day. The walker, and adding pad for falls from or by an dated 4/10/14 for potential elopement at risk related to function deficits, macular ressive deterioration of the processing surrounding the processing surrounding the provide the eye glasses in and provide the eye glasses in and provide the eye glasses in and provide the resident's ediately to the resident's d, would consistently note puts for safety reasons, assist when weather permitted, and does or grippers socks.  Indicate plan revealed on a staff found the resident for her/his room on her/his urine/BM and the floor was resident's range of motion. The bed alarm did not sound. In the for staff to replace the alarm lity's personal alarm (PA)	F 32	3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		17E294	B. WING			C 06/03/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY MEM HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097	I	00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 24	F 3:	23		
	3/12/14 at 11:15 A.M informed nursing staf between a recliner ar good ROM, alignmen extremities without di The intervention was frequently check the was on.  The nursing notes an 5/2/14 at 8:20 A.M. resident on the floor I	f the resident sat on the floor nd the wall. The resident had t and was able to move all fficulties. The alarm was off.				
	complained of right a 10 (being the worst p notified and an order The nursing intervent ensure the alarm was	rm/shoulder pain scoring a ain). The physician was for an x-ray was obtained. ion was for nursing staff to				
	revealed an impacted	I fracture at the surgical (right shoulder fracture).				
	revealed the resident her/himself from a w/ received a fracture of was resting comfortal ordered a shoulder in the family of the treat the resident to see ar	ated 5/2/14 at 12:45 P.M. fell while trying to transfer to to a chair. The resident the right humeral neck and bly in bed. The physician hmobilizer and staff notified ment and offered to send n orthopedic. Family t was on hospice and wanted				
	the February 2014, M	8/14 at 3:17 P.M. revealed larch 2014, and April 2014 ation Record (MAR) and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	` ′	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING _		06	C 5/03/2014
NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY MEM HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097	, ,	370072014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	documentation nursing resident's bed/chair at 2014 TAR revealed resident's personal at start on the night shift.  Observation on 5/28/resident laid in bed whorder air mattress where was within reach. Direction on 5/29/resident laid on a whomation on 5/29/resident's alarm mon nurse's station desk, and was verified by start the resident sat in an unursing station. No noursing station. At 8:: staff E and administration of the resident switched off.  Interview on 5/28/14 staff G stated the resident sat in a staff E and administration of the resident switched off.  Interview on 5/28/14 staff G stated the resident system, nursing daily and the alarm staff and the alarm staff and the staff A stated the resident staff A	ation Record (TAR) lacked any staff checked the alarm for function. The May pursing staff would check the larm on each shift and to at on 5/28/14.  14 at 1:05 P.M. revealed the with the bed in low position, a was in place, and the call light eet care staff G revealed the liter plastic alarm pad.  14 at 8:15 A.M. revealed the liter was located at the switched in the off position urveyor staff Z. At that time w/c by the fireplace near the larsing staff were at the 20 A.M. licensed nursing	F 3	23		

1 1		IDENTIFICATION NI IMPED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED C	
		17E294	B. WING	<del> </del>		06/03/2014	
NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY MEM HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097		1 00/00/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	documented on the check after her/his fastaff was not docum before that.  Interview on 5/29/14 nursing staff E reveal monitor should be on the charge nurse as hallway would check in the computer system. Interview on 5/29/14 administrative nursing did not have a policy monitoring.  The facility failed to planned for this cognitive that the computer is the computer system.	at 8:40 A.M. with ng staff B stated staff TAR the resident's alarm all on May 2nd but nursing enting the alarm checks at 10:12 A.M. with licensed aled the resident's alarm at all times and never off. esigned to the resident's at the alarm and documented em's TAR.	F 32	23			
	Set (MDS) 3.0 for re revealed a Brief Inte (BIMS) score of 2 w cognitive impairmen Review of the Care dated 7/23/13 for co resident had aphasis words.  Review of the commercealed the resider short and long term	Area Assessment (CAA) gnitive loss revealed the a and responded with few nunication CAA dated 7/23/13 at had aphasia, dementia with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E294 B. WING				C <b>06/03/2014</b>	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD		0/03/2014	
				408 DELAWARE ST			
JEFFERS	ON COUNTY MEM HOS	PITAL LICU		WINCHESTER, KS 66097			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From pag	e 27	F 3	23			
	revealed the resident to partial foot amputator of depression, an ordused pummel cushic raised area between discourage standing mat was next to the assist with reposition Review of the quarter revealed a BIMS sociated severe cognitive impunclear speech, usus sometimes could be resident required extibed mobility, transfet toileting, personal hy able to stabilize with to stand, walking, mosurface to surface traside, and used the wimobility. Review of the revise 5/8/14 revealed the respendition by the firmeals for increased staff were to continue every 2 hours, and a and with ambulation, the bottom outside of position of the bed, and Review of the care position of the standard stan	t was a high risk for falls due ation in the 1960's, a history hotic shoe for the right foot, in (a chair cushion with a the thighs) in the chair to without assistance, a floor bed, and quarter side rail to hing.  In MDS 3.0 dated 4/16/14 ore of 3 which indicated airment. The resident had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY MEM HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE ST WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 323	use of a personal ala Review of the medical record lacked or functioning of the Review of the nurses A.M. staff found the bathroom sitting upri Review of the fall inv 11:28 A.M. administrathere was lack of evifall on 3/24/14. Observation on 5/28, the resident was in because of the resident was in because of the resident sat in the room and a personal resident's shirt and the observation on 5/29, resident sat in the wide A personal alarm was shirt on the right should be observation on 5/29, the resident was in because of the resident was in the wide of the resident was in the located above the pill interview on 5/28/14 staff G stated he/she functioning every modificated the personal the paper activities of	d direction for staff on the arm. al record and the electronic d documentation of the use personal alarm. b' note dated 3/24/14 at 1050 resident on the floor in the ght with back against wall. restigations on 5/29/14 at rative staff B acknowledged dence of investigation for the 1/14 at 11:05 A.M. revealed red, the bed was in the low as next to the bed, and a reat the head of the bed. 1/14 at 11:39 A.M. revealed re wheelchair in the dining alarm was attached to the	F 32:	3		
	Interview on 5/28/14 stated the staff were	at 4:35 P.M. licensed staff P to check the alarm function t was transferred but not				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION IG	(X3) D	(X3) DATE SURVEY COMPLETED	
17E294			B. WING _			C 06/03/2014	
NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY MEM HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP COL 408 DELAWARE ST WINCHESTER, KS 66097		00/00/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 323	Interview on 5/29/14 nursing staff B stated the direct care staff p electronic medical re alarm. The facility failed to p and documentation of The facility failed to of	at 8:35 A.M. administrative difference was not a place on paper flow sheet or the cord to monitor the personal provide a policy on the used of a personal alarm.	F3	23			